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ABSTRACT

This document contends that gender has a significant impact on individual health status within the family. The Carter and McGoldrick (1989) family stage model is used to illustrate how gender and health interact within the family developmental process. The model of the traditional middle-class family life cycle is described as involving the following stages: the launching of the single young adult, the joining of families through marriage, the family with young children, the family with adolescents, the family at mid-life, and the family in later life. Each of these stages is seen as an epoch in which specific concerns or vulnerabilities occur in relation to gender and health. Health and gender issues for each of these stages are examined. For example, health issues considered in the first of these stages relate to Acquired Immune Deficiency Syndrome (AIDS) and mental illness, both of which involve significant gender differences. Citations from diverse sources illustrate characteristic health ramifications at each family stage. It is suggested that, depending upon the situation, gender can serve as either a vulnerability or protection factor. The document concludes that, although some gender-health disparities are due to physiology, many differences rest on socialization. A greater awareness of gender-health variations is considered helpful for anyone who works with families. (Author/NB)

The Interaction of Gender with Health and Illness Patterns in the Family Life Cycle: A Review

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Running Head: GENDER AND HEALTH IN THE FAMILY LIFE CYCLE

Abstract

Gender has a significant impact on individual health status within the family. To illustrate gender and health interactions, the Carter and McGoldrick (1989) family stage model is used. Citations from diverse sources illustrate characteristic health ramifications at each family stage. Depending upon the situation, gender can serve as either a vulnerability or protection factor. Although some gender-health disparities are due to physiology, many differences rest on socialization. Several of the gender differences offer no real advantage for either sex. In conclusion, greater awareness of gender-health variations is helpful for anyone who works with families.

The Interaction of Gender with Health and Illness Patterns in the Family Life Cycle: A Review

A myriad of important variables are critical to the understanding of human development and socialization. Given the dynamics of social institutions and other contextual states, it is advantageous to examine possible effects of any inherent elements (e.g., gender, birth order, intelligence) within the spheres of development. Conversely, it is also necessary to investigate the process that determines how an intrinsic variable functions within a context. Gender and health are examples of factors that exert an especially pronounced influence within and among other dimensions of development.

There are many ways to depict gender and health variations over the lifespan. For instance, an individual developmental perspective can provide a useful sequencing of examples. However, the family developmental context is likely to yield a richer, more comprehensive account. Although individual life cycle development remains a vitally important area of study, practically all individuals develop within a family. For most people, the family is the most basic and salient of all social institutions. A family usually includes both genders, as well as multiple generations, voluntary and involuntary relationships, and linear (even if irregular or occasionally broken) stages. Furthermore, transitional crises arising from family processes

may have differential effects on the genders. These differences may have implications for problem assessment, and for both individual and family treatment.

There is clear evidence that gender can serve as a vulnerability factor or protection factor with regard to a variety of health outcomes (Reddy, Fleming, & Adesso, 1992). Gender may predispose an individual to different maturation levels or distinctive interpretations of otherwise similar situations--just as the timing of an event may increase or decrease stress effects due to maturation, or change in the personal meaning of the event (Rutter, 1985). Moreover, exposure to concurrent multiple stressors can result in dramatic effects, whereas exposure to a single stress typically carries no appreciable risk. Conceivably, gender can influence how often a person is exposed to a particular type of event. For instance, if four times as many men as women are classified as heavy drinkers (Reddy et al., 1992), then women are more likely to have an alcoholic spouse than men.

There is also growing evidence of the importance of relatively minor life events (hassles) as a moderator of health (DeLongis, Coyne, Dakof, Folkman, & Lazarus, 1982). This concept recognizes the multiplicative effects of multiple stressors (Rutter, 1979), as well as the impact of clustered life events (Dohrenwend & Dohrenwend, 1977). Certainly, socially constructed meanings of gender can collide with whatever headaches or

inconveniences tend to be foisted on an individual, and how "hassling" those nuisances are perceived. Different gender combinations may alter the responses of both actor and target as well as the perceptions of those responses. Here are but two examples: a girl is generally not bothered very much if labeled a "sissy" (and, consequently, is unlikely to even encounter such an annoyance), whereas a man is less likely than a woman to experience sexual harassment as a result of unsolicited comments on his appearance.

To illustrate how gender and health interact within the family developmental process, the Carter and McGoldrick (1989) family life cycle stage model will be used as an outline. Their model of the traditional middle-class family life cycle includes the following stages: the launching of the single young adult, the joining of families through marriage (the new couple), the family with young children, the family with adolescents, the family at mid-life (launching the children and moving on), and the family in later life. Each of these stages is an epoch in which specific concerns or vulnerabilities occur in relation to gender and health.

A sticky issue involves the meaning of gender. Although sex and gender are frequently differentiated by using sex in reference to biological distinctions and gender to represent social constructions around sex, even the definitive reference source on sexology--A Descriptive Dictionary and Atlas of

Sexology--treats these terms as synonyms (Francoeur, Perper, Scherzer, Sellmer, & Cornog, 1991). Given that the nature and nurture components of gender remain equivocal, few such definitive distinctions between the biological components and the socially constructed aspects can be provided here.

Health is broadly defined here as the state of a person's physiological functioning at any given time. Of necessity, health status refers to the entire organism, including the state of the central nervous and endocrine systems. Thus mental disorders cannot legitimately be excluded from the discussion.

Some of the gender and health interactions may cross stages, and certain aspects of gender-health variations may be lifelong. Even so, family life cycles remain a useful way to organize and illustrate some of the distinctive gender and health combinations. The intent is to provide a picture of how gender influences health and family life, rather than to recommend the proper moral course for such relations. The reader is further warned that the examples provided are neither exhaustive nor evenly weighted within or among the stages. A final caveat before proceeding: within many of the presumed gender-health interactions, gender may actually be a proxy variable for some other mediating factor. This is especially probable with the socially constructed features of gender.

Leaving Home: Single Young Adults

Carter and McGoldrick's (1989) first stage involves an

individual achieving young adult status separate from the family of origin. This phase typically includes an independent period of time prior to formulating new family ties through marriage or other means. Thus it is an "in-between" stage for resolution of adolescent development, self-enhancement, experimentation, and solidifying adult status.

Relatively few gender-health differences emerge at this stage. It is widely recognized (even if contrary to longstanding cultural biases) that young men and women face similar rights, opportunities, and problems. Neither health problems (e.g., breast cancer, prostate cancer, heart disease) nor normative physical events (e.g., puberty, childbirth, decrease in acuity of the senses) are commonly associated with this stage. Nevertheless, there are relevant health concerns. Acquired immune deficiency syndrome (AIDS) and mental illness are two conditions that occur often enough during this period to bear mentioning. In both cases, there are significant gender differences.

Between one and two million American men and women are thought to be infected with human immunodeficiency virus (HIV; Curran, et al., 1988). However, the male to female ratio of the age-adjusted death rate from HIV disease is estimated to be between eight and nine to one (Frisby, 1993; Reddy et al., 1992). This is the largest gender difference among the top causes of death in the United States. Nonetheless, there is no evidence

that being female confers any special resistance to HIV or its consequence, AIDS. Vulnerability to HIV is greatly magnified by engaging in behaviors associated with high rates of infection--especially sexual behaviors that allow the exchange of blood or semen, or intravenous injection of drugs using shared needles.

AIDS is the second leading cause of death among men aged 24 to 45 and disproportionally affects gay men (Kelly & Murphy, 1992). Homosexual men who engage in high-risk sex even occasionally are in grave danger of contracting HIV infection and AIDS. Those who engage in unprotected anal sex with only one partner over one year are three times as likely to contract HIV as men who avoid unprotected sex in that same period of time (Kingsley et al., 1987).

Although males are more likely to engage in negative health-related behaviors in general (Reddy et al., 1992), risk-taking is not confined to men. In fact, AIDS is now one of the top ten causes of death among women of child-bearing age (Chu, Buehler, & Berkelman, 1990). Still, the risk for women is relatively less, and the women at the greatest risk of exposure to HIV are socioeconomically disadvantaged, African American urban women (Centers for Disease Control, 1991; Gwinn et al., 1991). Minority women understandably assign greater seriousness to problems of unemployment, child care, and crime than they do to susceptibility to HIV infection (Kalichman, Hunter, & Kelly, 1992). Thus the women most threatened by HIV are the same ones

who are most vulnerable to drug abuse, teenage pregnancy, other sexually transmitted diseases--or any other health problems related to being disadvantaged.

Death is the natural conclusion of life, but death of a young adult is unexpected, and often more disruptive to a family. The family may not get to complete the natural life cycle separation process, and the shock of the abrupt suspension of this process may be compounded by revelations about the victim's lifestyle. Additionally, the deaths of young, unmarried women create both immediate and long-range concerns for the well-being of the children left behind. Accordingly, health professionals need to be especially sensitive to the impact of any family secrets surrounding off-time deaths of either gender.

Gender may also play a significant role in outcome of serious mental illness at this stage. The most common form of psychosis is schizophrenia, affecting approximately one percent of the population (Carlson, 1991). Schizophrenia was previously named dementia praecox (early dementia) because it usually appears between the ages of fifteen and thirty (Miller & Galton, 1978). Thus the acute symptoms of the disease emerge at a time roughly corresponding with the single young adult phase.

Gender differences in mental illness outcomes may be due more to differences in social expectations and responses than to any fundamental physiological differences. For example, Salokangas and Stengard (1990) found that schizophrenic men

suffer from poorer working capacity, more negative symptoms, less satisfactory heterosexual relationships, and less overall functional abilities than their female counterparts. Schizophrenic men are especially lacking in basic social skills working capacity. These men are less likely to marry or otherwise establish intimate relations. Treatment methods more often address the needs and concerns of female schizophrenic patients than the specific needs of men suffering from the disease. Such gender discrepancies need to be addressed in order to improve service delivery to both these individuals and their families, as well as reduce gender discrepancies in treatment outcome.

The above examples by no means represent common occurrences during the single adult phase. Neither are they confined to this particular family developmental stage. They do, however, impart the exploratory flavor of the stage, and the associated risks to health, well-being, and social support. Furthermore, due to their care-providing roles, social service workers are likely to encounter a disproportionate number of young people presenting such health issues.

The Joining of Families Through Marriage

Two or more individuals bring previous family baggage (and aspects of their singleness) to forge a new family system--one that also bestows a relationship bond (however tenuous) among the contributing families of origin. Becoming a couple is a

difficult transition. Marriage requires reworking many established routines involving roles, the home base, decision-making, tasks, goals, and property. The stress associated with these changes can be significant.

Once again, health problems are far from the norm at this stage in life. Nonetheless, some gender variations in health outcomes occur with new couples. Some of the more noteworthy gender and health examples center around the impact of the decision to marry, the decision to parent or not, and whether to maintain sexual relations during pregnancy.

It has been claimed that for women, the changes wrought by marriage are so profound that they represent a health hazard (Bernard, 1982). Marriage appears to improve men's mental health as much as it negatively affects women (Apter, 1985). Married women do report more emotional problems and physical illnesses than married men. At least some of these differences are due to the fact that women (married or not) have higher morbidity rates for most diseases than men (Harrison, 1984; Reddy et al., 1992). (However, a bias may be operating here: perhaps women admit to physical, mental, and emotional difficulties more freely than men.)

The next example, the decision to become a parent, overlaps with the next stage: families with young children. (In fact this decision period could be viewed as a distinct family stage.) Notwithstanding that the decision to have children is often made

without a careful consideration of all the consequences, the resolution can have profound repercussions on both members of the couple. Becoming a parent changes relationships with family, friends, and work. But more often than not, the greater burden of adjustment will fall on the mother. Most young, educated people still hold the view that men belong in the breadwinner role and women belong in the role of nurturing the children at home (Bradt, 1989). Nevertheless, few families can afford the luxury of a caregiving homemaker of either sex. The social expectation that women are more responsible for childrearing compounds the stress when a woman returns to work, whether by choice or necessity.

Pregnancy provides an obvious gender disparity. In addition to the normal health concerns that accompany pregnancy, a couple's sexual health may become a factor. Sexual intercourse is safe during a normal pregnancy (Miller & Galton, 1978). Nevertheless, changes associated with pregnancy that impact on sexual expression may not be understood by both parties. For instance, there tends to be a gradual decline in female libido, frequency of sexual intercourse, and orgasm (Hart, Cohen, Gingold, Homburg, 1991). Even so, women initiate sex more often during pregnancy than they did before pregnancy. Dyspareunia (pain during sexual intercourse) is also commonly reported during this time (Hart et al., 1991). An awareness of these changes can facilitate sexual adjustment during gestation, and lessen the

chance of viewing normal consequences as health problems.

As previously stated, there are few gender-health differences at the beginning of marriage. Changes associated with moving from single to couple status are largely shared ones. Yet concerns that do exist due to sex differences should be acknowledged and affirmed. The repercussions of failing to address such situations may lead to more significant problems at later stages.

Families with Young Children

This stage of the family life cycle forces everyone to shift roles: children becoming parents causes parents to become grandparents, and siblings to become aunts and uncles. It also introduces a new individual into the family constellation, and lends the family more permanence. Consequently, new pressures of childcare, financial needs, and scheduling conflicts must be integrated among the new roles for the parents.

Mothers, unlike husbands and control subjects, show a significant decrease in marital satisfaction within the first six months of the child's birth (Cowan et al., 1985). Endocrine changes for the female can be more precipitous at this time than during puberty or pregnancy (Bradt, 1989). Postpartum changes may be more lasting than even these findings suggest. Apt and Hurlbert (1992) looked at mothers whose children's mean age was 33.6 months (range of 13 to 44 months) and found that they had a lower frequency of sexual activity, more negative attitudes about

sex, and a greater tendency to present themselves in a favorable light, as compared to women who were not mothers. The resulting strain on the marital relationship can feed back on the health of both individuals; however, such stress may often represent a greater threat to the woman's self-concept, well-being, and ultimately her overall health.

In our society, women are subjected to more pressure to become parents than men, and motherhood is often thought to fulfill needs for women that are not analogously inferred for men. Yet women are frequently perceived as having exercised a reasonably unfettered option in the decision to be a mother. Although rarely acknowledged as a source of tension for young married women, such personal conflicts do contribute to unwanted stress.

Moreover, the demands of job responsibilities outside of the home, combined with homemaking and childrearing, may produce unreasonable expectations for women. Quixotic demands do not just apply to mothers working outside the home. The requirements placed on many young mothers represent a dysfunctional process that remains far from being rectified (Avis, 1985). Mothers often assume a mythical importance in the development of their young children. Consequently, they have been unfairly blamed for situations they did not create. (The old terms refrigerator mother and schizophrenigenic mother illustrate the tendency to make women culpable even for the organic conditions of their

children.) In general, women do invest more in their children than men, and are therefore more vulnerable to accompanying anxiety and depression (Mills, Puckering, Pound & Cox, 1985). Such vulnerability reaches its greatest level in women who have three young children (Lampert & Freedman, 1992).

The stresses of motherhood and employment may be combined with low-status, low-paying employment. Such situations have been associated with health problems other than depression. For example, excess risk of coronary heart disease (CHD) occurs among female clerical workers with children (Haynes & Feinleib, 1980). Among working women, clerical workers who are married to blue collar workers have an increased risk of CHD. Such risks are exacerbated with the increasing size of the family, the tendency of the woman to suppress hostility, and remaining in a job with a nonsupportive boss.

Stress effects on women in turn have an impact on other family members. Although caution must always be used in assigning blame, mothers (as well as fathers) sometimes cause their children harm. Several forms of child abuse are widely identified and practically all jurisdictions have formal systems for intervention. Perpetrators and victims of abuse are not necessarily associated with a particular gender, and abusive situations can stem from psychopathology in either parent. However, it is not prudent to be completely gender-blind.

It is generally recognized that most perpetrators of sexual

abuse are male, and such abuse often occurs in the context of the family. A form of child abuse most often associated with mothers is Munchausen syndrome by proxy (MSBP; Mercer & Perdue, 1993). MSBP is a form of abuse in which the parent fabricates or induces a history and symptoms of disease in the child, resulting in unnecessary medical intervention, or treatment required by parent-created medical emergencies. Although MSBP is considered rare, it is underreported (like sexual abuse), due to the difficulties in detecting and documenting it. Mercer and Perdue suggest multiple functions for MSBP within family dynamics: a regulator of intimacy by providing a rationale for being out of the home, a help-seeking signal, a source of attention or support for the perpetrator, or a signal of extreme enmeshment and lack of protective mechanisms in the family. These mothers may be attempting to gain power in an oppressive environment, and in the process they become truly dangerous to their children.

The bottom line is that mothers, even more than fathers, often fail to receive support for the tasks that are expected of them in parenting. (Perhaps it is because mothers lack wives!) This lack of assistance can have negative ramifications for the mother's health, family adjustment, and the whole of society.

Families with Adolescents

Carter and McGoldrick (1989) see this stage as distinctive because parental authority is no longer so absolute as it might seem in families with young children. Adolescents tend to

introduce new friends and influences into the family circle. Boundaries become more flexible to accommodate the increasing independence of the next generation. In spite of that, allowing adolescents to have more autonomy must often proceed in the face of parents knowing that their adolescent children lack the maturity and skills to make good self-care decisions in an increasingly complex world.

There are other pressures operating in this stage. Parents are reaching middle age and midlife issues. Grandparents are approaching old age, infirmities, and the end of life. Marriages and careers are being reevaluated. College expenses and retirement planning may begin to conflict with each other. The divergent demands may get redefined or displaced onto the adolescents. Although most families make adequate adjustments to accommodate the changes, referrals to family therapy may peak in this family life cycle (Preto, 1989).

New health issues arise for mother, father, and adolescent. Adolescents must contend with puberty and the channeling of sexual expression. Parents begin to have a firsthand concern about health issues that were not a problem when they were younger. Once again, gender variations exist.

The appearance of puberty itself entails no serious gender and physical health disparities. However, socialization differences between the sexes may be responsible for some of the inconsistencies in sexual health adjustment between boys and

girls. Daughters certainly have more to fear in terms of rape, other sexual exploitation, and unwanted pregnancy. Consequently, a sexual double standard exists. Girls' sexual interests are discouraged more strongly than those of boys; by comparison, boys are less often seen as sexually exploited.

Notwithstanding the risks of sexual activity at this stage, the heightened fears and vigilance for girls has a downside: boys do not suffer from the sex-negative aspects of society to the same degree that girls do. The penis must be touched on a daily basis, a situation that naturally encourages exploration. A girl is not similarly disposed to become acquainted with her clitoris. The poor fit between girls' and boys' sexuality is fostered in part by our culture's emphasis on guilt and ignorance. As a result, sex for many girls is often something that "just happens," sometimes without actual consent, and often without adequate protection. Thompson (1990) maintains that most teenage girls need an erotic education to counteract the common female experience of pain and boredom surrounding sex. Moreover, effective contraception depends upon sexual confidence. However, so-called "erotic" education for girls is unlikely to occur when even basic sex education remains controversial. Parents can assist by encouraging their female children to become more knowledgeable of their own anatomy.

Teenage pregnancy is another area of sexual gender disparity. Using the state of Wisconsin as an example, there is

currently one reported live birth or induced abortion for every 27 females between the ages of 15 and 17 (Frisby, 1993). This estimate is actually low because it does not include miscarriages, and induced abortions performed outside of Wisconsin. The ratio grows to one in nine for 18 to 19 year old women. Nonetheless, though pregnancy may be risky for immature bodies, pregnancy and birth cannot by themselves be considered an abnormal health issue. However, the peculiarity of teenage girls (especially disadvantaged ones) being forced to accept childcare responsibilities seldom shared by the natural fathers, constitutes a major public health problem.

By no means do all the adolescent gender and health differences relate to sexuality and reproduction. Sex and gender interact in the development of eating disorders (Nagel & Jones, 1992). Anorexia nervosa and bulimia are far more common among young women than young men. Although such disorders may have a physiological basis, it is also quite plausible that cultural pressures that promote unrealistic body image expectations contribute to such disorders. (Perhaps the analogous situation among young men is the abuse of steroids in pursuit of excessive muscle mass.)

"Hardiness" is another variable that appears to interact with adolescent gender in predicting health outcomes. Shepperd and Kashani (1991) measured psychosocial stress and psychological symptoms in a sample of 75 boys and 75 girls. The "commitment"

and "control" components of hardiness show a strong gender difference: high-stressed males experience more physical and psychological problems if they register low on either commitment or control, but the same hardiness components do not interact at all with stress to predict health outcomes among females. (Low-stress males report few physical or psychological symptoms, regardless of hardiness levels.) Thus female well-being appears to be less constrained by the need for mastery of a situation, even as such needs appear to make boys more susceptible to negative stress effects.

Health concerns also begin to appear more commonly for parents in middle age. Overall, males at this stage tend to report fewer acute and chronic conditions than females (Reddy et al., 1992). Regardless, mortality rates tip the scales sharply in the other direction. The male death rate in fact exceeds the female rate in all age groups (Harrison, 1984). Between the ages of 35 and 64, almost twice as many men as women die each year. Aside from the large AIDS disparity, the causes of death with the largest gender differences include suicide, homicide, accidents, cirrhosis, pulmonary disease, and heart disease (Reddy et al., 1992). Behavioral factors are implicated in all of them.

The ratio of male to female deaths for both chronic heart disease and acute myocardial infarction is 2.4 to one (Harrison, 1984). Prospective studies have suggested an increased risk of CHD among working men, especially those with competitive, Type A

personalities (Barefoot, Dahlstrom, & Williams, Jr., 1983; Matthews, Glass, Rosenman, & Bortner, 1977). Cultural expectations that teach men to respond to stressors in an excessively competitive fashion are a likely contributor to excessive male mortality. Additionally, there is limited evidence that testosterone tends to speed blood clot formation, whereas estrogen tends to slow it (Reddy et al., 1992). Moreover, Waldron (1986) estimates that cigarette smoking patterns account for between 40 and 60 percent of the gender difference in mortality for all causes.

The Type A personality is not gender-specific, but gender may figure prominently in any effects of this personality characteristic on children. There appears to be a cross-gender pattern between parents' Type A personality behavior pattern and their older adolescent children: Type A in fathers is related to Type A in daughters, and Type A in mothers is related to Type A in sons (Forgays & Forgays, 1991). Even so, the outcome of passing this personality to boys may be more negative, due to an interaction with a male tendency toward intemperate use of cigarettes, alcohol, and other substances deleterious to health.

Launching the Children

This phase of family development can sometimes bring on a long and difficult adjustment. Although some children launch themselves relatively early, some young adults remain at home for many years, in order to avail themselves of ready structure,

"cheap rent," and other amenities of a lifestyle they cannot afford on their own. Those children who do leave begin to bring back new family members. Grandparents often become very old or ill during this phase. This stage can also introduce new freedoms for parents, but this may be less true if one or more children fail to be launched in a timely fashion.

CHD continues to be a prominent health problem for men in this age group, but now CHD begins to occur in significant numbers among women. Prior childbearing appears to produce an increased risk of CHD for working women past the age of 50 (Haynes & Feinleib, 1980). This finding, however, may say more about the accumulated stresses from years of simultaneous childrearing and breadwinning, than it does about any physiological protection afforded by childlessness. Furthermore, it is at about this age that the purported protection provided by estrogen begins to fade through menopause.

Menopause itself is no more of a "health problem" than any other developmental milestone. Nonetheless, CHD, higher blood pressure, more rapid blood coagulation rates, and bone density losses are associated with the postmenopausal years (Crosignani, 1992). As more of a woman's expected life occurs postmenopause, the associated health problems assume a greater importance in preventive medicine.

The use of estrogen replacement therapy appears to reduce morbidity and mortality associated with CHD and in addition,

remains the most effective therapy for prevention of bone loss in later years (Crosignani, 1992). Another reported problem for menopausal women is dyspareunia. Estrogen replacement therapy will often restore the tissue of the reproductive tract enough to relieve this condition (Sherwin, 1991). However, the study of the effects of estrogen, in combination with different progestins, is far from complete; thus women experiencing postmenopausal health symptoms need to rely on their physician's best advice on benefits and risks of estrogen replacement.

An analogous stage problem for males involves the prostate gland. Autopsy studies have shown that 50 to 60 percent of men over the age of 50 have significant enlargement of this organ (Smolev, 1984). Known as benign prostatic hypertrophy, it can lead to urinary obstruction and increased urinary frequency. Surgery may be necessary to relieve these symptoms. Although regular physical examinations by a physician can uncover any developing prostate problem, many men avoid regular checkups.

Breast cancer is a far more serious health problem for women than for men in this age group. Women over age 50 account for 80 percent of all breast cancers (Newsweek, March 8, 1993). It is the most commonly diagnosed cancer among women and the second leading cause of death from cancer in women (Morbidity and Mortality Weekly Report, June 26, 1992). The incidence of breast cancer has increased dramatically in recent years: from 1980 to 1987 alone, the rate increased from 94.6 to 124.3 per 100,000

women in the United States (MMWR, June 26, 1992). The rate has been climbing for at least 40 years (Kessler, Feuer, & Brown, 1991), and only part of the increase is accounted for by increased detection rates (Liff, Sung, Chow, Greenberg, & Flanders, 1991). These statistics argue for the regular use of mammography screening for any woman in this age group--as well as for the allocation of greater resources for prevention and treatment of this disease.

Depression is infrequently associated with this stage, but its occurrence has resulted in the often misleading term empty nest syndrome--usually applied only to mothers. Regardless of incidence, any depression at this stage should be treated seriously. There is evidence linking symptoms of helplessness and passivity with host vulnerability and more rapid malignant tumor growth in animal studies (Sklar & Anisman, 1979; Laudenslager, Ryan, Drugan, Hyson, & Maier, 1983). In a study of breast cancer patients, a combination of depression, apathy, fatigue, listlessness, and a lack of social support was associated with the worst biological outcomes (Levy, Herberman, Maluish, Schlein, & Lippman, 1985). Preventive medicine must, therefore, address the individual's emotional adjustment.

Older women will more often than not live alone, have lower incomes than their male counterparts, and be unlikely to remarry (McGoldrick, 1989). In some cases, these a person's best efforts at coping will not be adequate to alleviate the disabling effects

of stress. Grief, loneliness, and readjustment to new circumstances are often a requirement of these women. Still, it is doubtful that women in this age group engage in coping strategies that put them at greater risk for disease. After all, they are less likely to die than their husbands, and there are more widows than widowers in families at the launching phase.

Families in Later Life

Families in later life must adjust to retirement, significant losses of friends and relatives, changing abilities, decreasing power in the extended family, and the eventual loss of a spouse. Nevertheless, it can also be a time of freedom from many former responsibilities, and of rewarding, yet fairly unconstrained relationships with grandchildren. It is likewise the last stage, ushering in a compulsory period where the essential facts of life--both devastating and sublime--become accessible to the entire family.

Given enough time, widowhood becomes the most common female experience. The unyielding gender difference beginning at conception, which mandates that males will die in greater numbers than females, does not change at this stage. Men continue to die in greater numbers than women until both sexes are past the age of 80; by that time, the greater number of female to male deaths only indicates that most of the men have already died (Harrison, 1984). Why the male lifespan is shorter remains subject to much conjecture. There are some biological differences, but such

things as greater male vulnerability to infectious diseases and the contributions of sex hormones to heart disease risk, do not begin to account for all the variance (Reddy et al., 1992). Certainly, social behavior differences must account for some of the disparity.

The longer an individual lives, the more likely it becomes that the person will contract a debilitating illness. Death closes the last chapter on development. Nonetheless, that is tempered by a reasonable expectation of many years of life in this family phase. If women are used as the standard, the average age of death is now almost 84 years (Reddy et al., 1992). And the older an individual gets, the more the statistical life expectancy projects beyond that mark (i.e., an 89 year old still has a life expectancy, and it exceeds 89 years).

For women who attain this age group, two gender-related conditions represent health threats: breast cancer and osteoporosis. Although breast cancer incidence rises dramatically with age, whether women older than 75 years actually have as much risk as women in the previous family stage is not clear; recent evidence of decreased risk after that age may be an artifact of increased breast cancer screening (Kessler, 1992). Nevertheless, the risk of osteoporosis for older women is not in question. By the year 2025 approximately 20 percent of the world's population will be older than 60 years (Crosignani, 1992). Medical science will have to address the health problems

linked with postmenopausal bone loss, and those who provide treatment will have to assist greater numbers of families in adopting practices to help ameliorate the condition.

A comparable health concern for males in this age group is the growing threat of prostate cancer. Prostatic carcinoma is primarily a disease of men aged 60 and older (Smolev, 1984). However, prostate cancer is the second most common cancer among all men and the current lifetime risk for an American male is about one in 11 (MMWR, June 12, 1992). Incidence of the disease rises very sharply after the age of 70 (Heshmat, et al., 1992). Furthermore, the incidence appears to be rising overall as the disease appears even later in life: in a study of black patients at Howard University Hospital, the median age at diagnosis of cancer increased eight years between 1968 and 1989 (Heshmat, et al., 1992). Perhaps the increased incidence is a natural consequence of living longer.

Health maintenance and coping with illness are perhaps most salient at this phase of the family process. Although it is still more likely that the bulk of any "hands-on" caregiving will be done by women (McGoldrick, 1989), all younger family members will all have to contend with loss of the oldest generation. In that regard, there is no gender disparity.

Conclusions

This brief analysis of gender and health within the Carter and McGoldrick (1989) family life cycle model gives recognition

to some worthwhile gender-health distinctions. It is reasonable and appropriate to acknowledge gender differences based on physiology, as well as those due to the socialization effects of a sexist culture. Some of the gender disparities need such acknowledgement in order to be reduced. Undoubtedly, it is true that certain health risks created by learning are modifiable, even if no adequate blueprint for the required cultural remodeling presently exists. Other health differences may be less subject to modulation. In any case, gender differences are real, are likely to remain with us for some time to come, and will on occasion have negative ramifications.

Any discussion of gender-health differences must affirm that women and men are more alike than not. Still, aside from the obvious physical differences--and the often-reported slight dissimilarities in aggression, and verbal and spatial abilities--other gender differences exist. Even though men and women by and large experience similar health opportunities and risks, some of the persisting "constitutional" differences do favor women. For instance, the female brain appears to be more robust (Lansdell, 1989). Girls show less relationship between attachment problems and later psychopathology than boys (Lewis, Feiring, McGuffog, & Jaskir, 1984). It is even possible that, through state dependent effects on cognition and behavior (due to the greater number of hormone shifts during menstruation, pregnancy, childbirth, postpartum, nursing, and menopause), women are more

constitutionally open to beneficial personality transformations (Rossi, 1986). If women are used as the standard for health, the recognition of such differences could eventually serve to benefit men as well.

Meanwhile, the examples provided here are meant to lend further legitimacy to a (nonsexist) examination of gender and health by those who provide supportive services to families at any life stage. At the same time, it is understood that citing biologically unique aspects of the female gender has rarely proven to be very useful in the pursuit of equality! However, even though fundamental gender differences may exist, it must be continually emphasized that many of the existing gender-health disparities are merely the result of being socialized as one gender or the other. More to the point, many of the current socially constructed gender differences represent no advantage to either women or men.

Gender impact on health status within the family can be consequential or trivial. Present-time critical differences not only have implications for family treatment, but more generally for long-term modification of family roles and structures in ways that reduce unnecessarily discrepant influences on health. And ultimately, awareness of gender's impact on health and family life should encourage beneficial social changes, as well as honest celebration of the differences that justify the existence of separate genders in the first place.

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